AFFIDAVIT FOR REPLACEMENT OF FOOD STAMP BENEFITS

State Form 40988 (R6 / 6-05) / FI-FS 0048

Division of Family Resources / FSSA

County OFR
Case name
Case number

INSTRUCTIONS TO CLIENTS: If a replacement issuance is being requested you must complete this form (FI-FS 0048). It should be completed and returned to the County Office of Family Resources (OFR) within ten (10) days of the loss.

If you are unable to bring it to the office due to age, handicap, or lack of transportation and you are unable to appoint an authorized representative the FI-FS 0048 can be mailed to the OFR upon completion.

INSTRUCTIONS TO COUNTY OFR: The county OFR must prepare two (2) copies of all affidavits for replacing Food Stamp benefits. (FI-FS 0048). Provide one (1) copy to the participant or authorized representative and keep the original in the case file.

PARTICIPANT AFFIRMATION

I, _____ , am requesting that the _____ County Office of Family Resources / FSSA issue replacement food stamp benefits.

My food purchased with Food Stamp benefits was destroyed in a disaster (*Specify*): _____

_____

_____

Estimated amount of loss $ _____ .

AFFIDAVIT AND SIGNATURE

I AFFIRM THAT THE REPLACEMENT OF MY FOOD STAMP BENEFIT LOSS IS DUE TO A DISASTER AND THE AMOUNT OF MY LOSS IS MY BEST POSSIBLE ESTIMATE. I UNDERSTAND IF I KNOWINGLY GIVE FALSE OR MISLEADING INFORMATION IN ORDER TO BECOME ELIGIBLE FOR FOOD STAMP BENEFITS I MAY BE PROSECUTED UNDER ALL APPLICABLE STATE AND FEDERAL LAWS.

I DO SOLEMNLY SWEAR *(OR AFFIRM)* UNDER PENALTY OF PERJURY THAT ALL STATEMENTS MADE IN THE ABOVE REQUEST ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. *(If participant affirms, the swear should be crossed out.)*

Signature of participant or authorized representative	Date

Witness *(If signature is by "X")*

Address of witness *(number and street, city, state, ZIP code)*

FOR AGENCY USE ONLY

_____ AMOUNT OF REPLACEMENT ALLOTMENT _____

_____ COLLATERAL CONTACT MADE *(Explain in comments)*

_____ BENEFITS NOT REPLACED: REASON _____

Comments: